

Item 20b Film 223 12-8-57

11846

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg - Rural c. LENGTH OF STAY IN 1b xx2 Rhodesdale - Rural d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Near Finchville				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) xx2 Rhodesdale - Rural d. STREET ADDRESS Near Brookview e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Wyatt Middle Jefferson Last Arnett				4. DATE OF DEATH Month November Day 28 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 8, 1924	9. AGE (In years last birthday) 33 yrs.	IF UNDER 1 YEAR Months 33 Days 33 Hours 33 Min.	IF UNDER 24 HRS. Hours 33 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Operator		10b. KIND OF BUSINESS OR INDUSTRY Dupont Company		11. BIRTHPLACE (State or foreign country) New Castle, Delaware		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harry J. Arnett				14. MOTHER'S MAIDEN NAME Mannie E. Marine			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW II 180-16-6747		17. INFORMANT Address Mrs. Wyatt J. Arnett, Rhodesdale, Md., RFD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Inter Cranial injury 822x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Multiple fractures skull DUE TO (c) Instant						INTERVAL BETWEEN ONSET AND DEATH Instant	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of auto which overturned.					
20c. TIME OF INJURY Month, Day, Year 1:10 p.m. 11/28 57	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway 392	20f. (City or town) Finchville, Dor.	(County) Md.	(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>John Mace Jr.</i> EXAMINER'S NAME (Type) Dr. John Mace Jr.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Dec. 1, 1957		22c. NAME OF CEMETERY OR CREMATORY Washington Cemetery	
22d. LOCATION (City, town, or county) Harlock, Maryland				(State) Md.			
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalsburg, Maryland				24a. REC'D BY REGISTRAR DEC 5 57		24b. REGISTRAR'S SIGNATURE <i>W. H. ...</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MISSOURI STATE EXAMINER'S CERTIFICATE OF DEATH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
DEC 5 1957
BUREAU V. 3

11845

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester Co. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Dorchester Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge RFD #3				c. LENGTH OF STAY in 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge RFD # 3				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Margaret E. Middle Bennett Last 				4. DATE OF DEATH Month Nov Day 3 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/31/1869	
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 		IF UNDER 24 HRS. Months Days Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Cambridge RFD # 3	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME William J. Rhea				14. MOTHER'S MAIDEN NAME Martha Spedden			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT George H. Bennett Address Cambridge RFD # 3	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure 334x DUE TO (b) Starvation DUE TO (c) Psychosis and Coronary Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary Tuberculosis (Extensive)							INTERVAL BETWEEN ONSET AND DEATH 2 weeks
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 11/20 , 19 50 , to 11/3 , 19 57 ; that I last saw the deceased alive on 11/3 , 19 57 ; and that death occurred at 6 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE W. H. Hanks M.D.				ADDRESS (Street, city or town, state) 104 Howard St Cambridge Md DATE SIGNED 11/4/57			
PHYSICIAN'S NAME (Type) W. H. Hanks							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/5/57		22c. NAME OF CEMETERY OR CREMATORY Spedden Swards		22d. LOCATION (City, town, or county) (State) Neck Dist. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service				ADDRESS Cambridge Md.		24a. REC'D BY REGISTRAR DATE 11/4/57	
				24b. REGISTRAR'S SIGNATURE John M. J.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

[Faint, mostly illegible text and markings on the certificate form, including fields for name, date, and cause of death.]

BUREAU OF VITALS

NOV 13 1957

RECEIVED

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11830 CERTIFICATE OF DEATH

11843

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Dorchester Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge Md.</u>				c. LENGTH OF STAY IN lb <u>2 Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Cambridge Md. Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Zella</u> Middle <u>Ellen</u> Last <u>Booze</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>8</u> Year <u>19 57</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6 /14/1886</u>	9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Hoopersville Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel T. Hooper</u>				14. MOTHER'S MAIDEN NAME <u>Susan Meekins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mr. Romie C. Booze</u> Address <u>Hoopersville Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>Hypertensive Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>yes</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 12, 1957</u> , to <u>Nov. 8, 1957</u> , that I last saw the deceased alive on <u>Nov. 8, 1957</u> , and that death occurred at <u>10 45</u> AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. Baumann</u> M.D.				ADDRESS (Street, city or town, state) <u>Cambridge, Md.</u> DATE SIGNED <u>11-9-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/10/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Dorchester Mem. Park</u>		22d. LOCATION (City, town, or county) (State) <u>Cambridge Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>LeCompte Funeral Service</u>				ADDRESS <u>Cambridge Md.</u>		24a. REC'D BY REGISTRAR DATE <u>11/11/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>John Meekins</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 will be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

BUREAU V. 5

NOV 13 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G223 12-2-57 et

CERTIFICATE OF DEATH

11844

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>rural Cambridge</u>				c. LENGTH OF STAY IN 1b <u>2 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Secretary</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eastern Shore State Hospital</u>				d. STREET ADDRESS <u>-</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Herman</u> Middle <u>Clifford</u> Last <u>Bounds</u>				4. DATE OF DEATH Month <u>November</u> Day <u>22</u> Year <u>19 57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>January 4, 1884</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer - waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Hubert J. Bounds</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Malone</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Eastern Shore State Hospital records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocardial Degeneration</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>-</u> DUE TO (c) <u>-</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senile Psychosis</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>9-28</u> <u>1957</u> , to <u>Nov 22</u> <u>1957</u> , that I last saw the deceased alive on <u>Nov 22nd</u> <u>1957</u> , and that death occurred at <u>2:00 P.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Thomas J. Dredge</u> M.D. <u>E.S.S. Hospital, Cambridge, Md.</u>							
PHYSICIAN'S NAME (Type) <u>Thomas J. Dredge, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Removal</u>		<u>11/25/57</u>		<u>East New Market</u>		<u>East New Market, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
<u>John S. McElroy, Jr., E. N. Market</u>				<u>DATE</u>		<u>John McElroy Jr.</u>	

CERTIFICATE OF DEATH

<p>NAME OF DECEASED</p>		<p>AGE</p>		<p>SEX</p>	
<p>DATE OF DEATH</p>		<p>TIME OF DEATH</p>		<p>PLACE OF DEATH</p>	
<p>CAUSE OF DEATH</p>		<p>MANNER OF DEATH</p>		<p>REPORTED BY</p>	
<p>SIGNATURE OF PHYSICIAN</p>		<p>SIGNATURE OF REGISTRAR</p>		<p>DATE OF REGISTRATION</p>	

BUREAU V. 2

NOV 27 1957

RECEIVED

11848

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY DORCHESTER Bal.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Taylor's Island			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> Baltimore 3V01-4		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Taylor's Island			d. STREET ADDRESS 1212 Steelton Ave.		
3. NAME OF DECEASED (Type or print) Garfield Buddy Clark			4. DATE OF DEATH Nov. 8 1957		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/17/1926		9. AGE (In years last birthday) 31 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Crane Operator		10b. KIND OF BUSINESS OR INDUSTRY Steel Mfg.		11. BIRTHPLACE (State or foreign country) W. Va.	
13. FATHER'S NAME Thomas Edward Clark		14. MOTHER'S MAIDEN NAME Bertha (unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 235-38-4663		17. INFORMANT Mrs. Swannie Belle Clark 1212 Steelton Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 850.x Accidental Drowning IMMEDIATE CAUSE (a) 850.x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 850.x DUE TO (c) 850.x					INTERVAL BETWEEN ONSET AND DEATH Instant
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 850.x					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Boat capsized.			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 10-8- 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Bay	
20f. (City or town) Nr. Taylor's Island		20g. (County) Md.		20h. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE John Mace Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 10/9/57	
EXAMINER'S NAME (Type) John Mace Jr.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/13/57		22c. NAME OF CEMETERY OR CREMATORY Baltimore Nat. Cemetery	
22d. LOCATION (City, town, or county) Baltimore		22e. (State) Md.		22f. REC'D BY REGISTRAR 11/14/57	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tickner & Sons		ADDRESS Baltimore 17, Md.		24b. REGISTRAR'S SIGNATURE John Mace Jr.	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH-EVENTS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination details, including fields for name, age, sex, date of death, and cause of death. The form is mostly blank with some faint markings.

BUREAU V. S.

NOV 25 1957

RECEIVED

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
11831 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11846

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester Co.</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Dorchester Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge Md.</u>		c. LENGTH OF STAY IN 1b <u>1 Hour</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cambridge Md. Hospital</u>		e. STREET ADDRESS <u>218 Academy St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Eva</u> Middle <u>Jones</u> Last <u>Collins</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>30</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/25/1895</u>
9. AGE (in years last birthday) <u>62</u> yrs		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Bishops Head Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Alfred E. Jones</u>		14. MOTHER'S MAIDEN NAME <u>Mary A. Moore</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>	
17. INFORMANT <u>Joseph M. Collins</u>		Address <u>218 Academy St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John Mace Jr.</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Dr. John Mace Jr.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/2/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Dorchester Mem. Park</u>		22d. LOCATION (City, town, or county) (State) <u>Cambridge Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>LeCompte Funeral Service</u>		24a. REC'D BY REGISTRAR <u>DATE 11/30/57</u>	
ADDRESS <u>Cambridge Md.</u>		24b. REGISTRAR'S SIGNATURE <u>John Mace Jr.</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

DEC 4 1957

BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No. 276

1. PLACE OF DEATH a. COUNTY <u>Eastern Shore State Hosp - MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md -</u> b. COUNTY <u>TA/1601</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OXFORD Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eastern Shore State Hosp -</u>		d. STREET ADDRESS <u>Stewart Ave -</u>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Henry</u> Last <u>Collison</u>		4. DATE OF DEATH Month <u>11</u> Day <u>28</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-16-1870</u>
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber -</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Delaware</u>	
11. BIRTHPLACE (State or foreign country) <u>US -</u>		12. CITIZEN OF WHAT COUNTRY? <u>US -</u>	
13. FATHER'S NAME <u>Wm. H. Collison -</u>		14. MOTHER'S MAIDEN NAME <u>Bell -</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u>214-32-7452</u>	
17. INFORMANT <u>Charles C. Collison</u> Address <u>Newcastle Del</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma prostate & Metastasis to Spine</u> 177X DUE TO (b) <u>Generalized Arterio-sclerosis</u> (c) <u>Chr. Brain Syndrome & Psychosis</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Secondary Anemia -</u>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. p. <u>19</u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I attended the deceased from <u>1-28</u> , 1957, to <u>11-28</u> , 1957, that I last saw the deceased alive on <u>11-28</u> , 1957, and that death occurred at <u>1:00</u> M, from the causes and on the date stated above			
ACTUAL SIGNATURE <u>Edwin Howard</u> M.D.		ADDRESS (Street, city or town, state) <u>Noon</u> DATE SIGNED <u> </u>	
PHYSICIAN'S NAME (Type) <u> </u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec 2, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Brookland Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Brookland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Maurice E. Krummason</u> ADDRESS <u>Boston, Md</u>		24a. REC'D BY REGISTRAR <u> </u> 24b. REGISTRAR'S SIGNATURE <u> </u>	
DATE <u>12/2/57</u>		DATE <u>7/2/57</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 1 may be retained by the hospital or attending physician. The law requires that the death certificate be signed by the attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S. AIR MAIL

EC

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PK-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11832

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11847

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Madison, Md.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cambridge Md. Hospital</u>				d. STREET ADDRESS <u>/</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Preston</u> Last <u>Cooper</u>				4. DATE OF DEATH Month <u>NOV.</u> Day <u>16</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/26/17</u>		9. AGE (in years last birthday) <u>40</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gen. Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Marvin Cooper</u>				14. MOTHER'S MAIDEN NAME <u>Jane E. Keene</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Police Dept. Cambridge, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Intercranial injury</u> <u>781X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Shot gun wound of head.</u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>New min.</u>					
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot gun wound of head.</u>					
20c. TIME OF INJURY Hour <u>11</u> p.m. Month <u>Nov.</u> Day <u>16</u> Year <u>57</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Parked car.</u>		20f. (City or town) <u>Cambridge, Dor.</u> (County) <u>Md.</u> (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>John Mace Jr.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Dr. John Mace Jr.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/20/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Madison Cemetery</u>		22d. LOCATION (City, town, or county) <u>Madison, Md.</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Herbert St. Clair</u>				24a. REC'D BY REGISTRAR <u>John Mace Jr.</u>		24b. REGISTRAR'S SIGNATURE <u>John Mace Jr.</u>	

MEDICAL CERTIFICATION

U. S. DEPARTMENT OF AGRICULTURE

27 AUG.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11848

Item 2, Film G222, 11/15/57

11833

CERTIFICATE OF DEATH

Reg. Dist. No.

116

1. PLACE OF DEATH a. COUNTY DORCHESTER MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY DORCHESTER	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMBRIDGE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 CAMBRIDGE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CAMBRIDGE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GILBERT Middle COTTMAN Last COTTMAN		4. DATE OF DEATH Month II Day I Year 1957	
5. SEX MALE	6. COLOR OR RACE COLORED	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH ?
9. AGE (In years last birthday) yrs. 62		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABOR	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME ROUTH COTTMAN		14. MOTHER'S MAIDEN NAME MOLLIE BEVINS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-38-5538	
17. INFORMANT ALBERT COTTMAN PRINCESS ANNE, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LOBAR PNEUMONIA. 490x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) T.B.C. + SYPHILIS DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 10 DAYS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 22 OCT, 1957 to 1 NOV, 1957 that I last saw the deceased alive on 1 NOV, 1957 , and that death occurred at 11:25 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 105 CHURCH DATE SIGNED 4 NOV	
ACTUAL SIGNATURE Walter E. Gunby Jr.		PHYSICIAN'S NAME (Type) WALTER E. GUNBY JR. CAMBRIDGE MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11/10/57	
22c. NAME OF CEMETERY OR CREMATORY ST MARKS		22d. LOCATION (City, town, or county) (State) OAKVILLE MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE William R. James Jr. Princess Anne, Md.		24a. REC'D BY REGISTRAR NOV 12 1957	
24b. REGISTRAR'S SIGNATURE John M. Jones Jr.			

RECEIVED

NOV 12 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11850

CERTIFICATE OF DEATH

11849

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>rural Cambridge</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eastern Shore State Hospital</u>		d. STREET ADDRESS <u>2040...</u>	
3. NAME OF DECEASED (Type or print) <u>MATTIE</u> First Middle Last <u>Councell</u>		4. DATE OF DEATH <u>Nov 10th</u> 1957	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 27 1871</u>
9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Smith</u>		14. MOTHER'S MAIDEN NAME <u>Not Known</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address <u>Eastern Shore State Hospital records</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>General Arteriosclerosis</u> <u>450.0</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Link</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March 28, 1956</u> , to <u>Nov 10, 1957</u> , that I last saw the deceased alive on <u>Nov 10, 1957</u> , and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas J. Dredge</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>E.S.S. Hospital, Cambridge, Md. Nov 10 '57</u>	
PHYSICIAN'S NAME (Type) <u>Thomas J. Dredge, M.D.</u>			
22a. BURIAL CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>Nov 13, 57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Easton</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. ...</u>		24a. REC'D BY REGISTRAR <u>Nov 13 1957</u>	24b. REGISTRAR'S SIGNATURE <u>John M. ...</u>

RECEIVED

NOV 13 1957

BUREAU V. S.

11834 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Dorchester Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>114 Glasgow St.</u>		d. STREET ADDRESS <u>114 Glasgow St.</u>	
3. NAME OF DECEASED (Type or print) First <u>A.</u> Middle <u>Hallie</u> Last <u>Creighton</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>25</u> Year <u>19 57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/16/1876</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR Months <u>3</u> Days <u>20</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fishing</u>	
11. BIRTHPLACE (State or foreign country) <u>Hoopers Island Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert T. Creighton</u>		14. MOTHER'S MAIDEN NAME <u>Addie Meekins</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-12-6732</u>	
17. INFORMANT <u>Hallie Creighton</u>		Address <u>Cambridge Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO <u>atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Decomposed to the point of death</u> DUE TO (c) <u>5 yrs.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>5 yrs.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>10</u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While (Not while) of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Cambridge Md.</u>	
21. I certify that I attended the deceased from <u>June 24, 1957</u> , to <u>Nov 25, 1957</u> , that I last saw the deceased alive on <u>Nov 24, 1957</u> , and that death occurred at <u>6:47 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. B. E. Meekins</u>		DATE SIGNED <u>Nov 25, 1957</u>	
PHYSICIAN'S NAME (Type) <u>GILBERT E. MECKINS</u>		ADDRESS <u>Cambridge Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/27/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Dorchester Mem. Park</u>	22d. LOCATION (City, town, or county) (State) <u>Cambridge Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>LeCompte Funeral Service</u>		ADDRESS <u>Cambridge Md.</u>	
24a. REC'D BY REGISTRAR <u>DATE 11/30/57</u>		24b. REGISTRAR'S SIGNATURE <u>John M. ...</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
DEC 7 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11851

11835

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 shall be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Dorchester Co.</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Dorchester Co.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge Md.</u>		c. LENGTH OF STAY IN 1b <u>2 Yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge Md.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Glenburn Convelesent Home</u>			d. STREET ADDRESS <u>Cambridge Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Sallie Wilson Dail</u>			4. DATE OF DEATH Month Day Year <u>Nov. 24, 19 57</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/1/1866</u>		9. AGE in years (last birthday) <u>91</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Cambridge RFD # 3</u>	
13. FATHER'S NAME <u>Levin Dail</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
14. MOTHER'S MAIDEN NAME <u>Sarah E. Wilson</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>None</u>			17. INFORMANT <u>Wilson Dail</u> Address <u>Cambridge Md.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause lost. (c) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Cambridge Md.</u>	
20f. (City or town) <u>Cambridge</u>		20g. (County) <u>Md.</u>		20h. (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>John Mace Jr.</u>		EXAMINER'S NAME (Type) <u>Dr. John Mace Jr.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>11/29/57</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/26/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cambridge Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Cambridge Md.</u>		22e. (State) <u>Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>LeCompte Funeral Service</u>			24a. REC'D BY REGISTRAR DATE <u>11/29/57</u>		
24b. REGISTRAR'S SIGNATURE <u>John Mace Jr.</u>					

RECEIVED
DEC 4 1957
BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18
11836 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13072

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>				c. LENGTH OF STAY IN 1b <u>30</u> years			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cambridge Md. Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Emma</u> First <u>Luveina</u> Middle <u>Dashfield</u> Last				4. DATE OF DEATH Month <u>Nov.</u> Day <u>29</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> <u>DIVORCED</u> <input type="checkbox"/>		8. DATE OF BIRTH <u>Unknown 1894</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>							
13. FATHER'S NAME <u>Train Bechum Weatherley</u>				14. MOTHER'S MAIDEN NAME <u>Mary Young</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO (If yes, give war or dates of service) <u>213-14-7606</u>		17. INFORMANT <u>Daniel Weatherley- brother</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]				INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracranial injury</u>				<u>1 day</u>			
DUE TO (b) <u>Multiple fractures of skull.</u>				<u>1 day</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Was struck by a car while walking on road.</u>			
20c. TIME OF INJURY Month, Day, Year <u>5:50</u> <u>11/23</u> <u>57</u> Hour <u>5:50</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Glasgow St.</u>	
20f. (City or town) <u>Cambridge, Dor.</u>				20g. (State) <u>Md.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John Mace Jr.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Dr. John Mace Jr.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>12/3/57</u>			
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/4/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Aireys Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Aireys Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leon W. Henry</u>				ADDRESS <u>Cambridge, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>12/3/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>John Mace Jr.</u>			

DEPT. OF AGRICULTURE

TO O 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11851

CERTIFICATE OF DEATH

11852

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 1 mo. 7 das.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital		d. STREET ADDRESS Route #2.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Estelle Middle Lee Last Dennis		4. DATE OF DEATH Month November Day 12 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-21-04
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Parsons (James M. Parsons)		14. MOTHER'S MAIDEN NAME Ernie (Olevia Ernie Perdue)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] no		16. SOCIAL SECURITY NO. -	
17. INFORMANT RECORDS - Eastern Shore State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] And Mr. Archie Dennis (Husband) Parsonsburg, Maryland. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Encephalitis 307X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Chronic Brain Syndrome With Psychosis DUE TO (c) -			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 5, 19 57 to November 12, 19 57 , that I last saw the deceased alive on November 12, 19 57 , and that death occurred at 4:25 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Edwin J. Ward		ADDRESS (Street, city or town, state) DATE SIGNED November 12, 1957	
PHYSICIAN'S NAME (Type) Dr. Edwin J. Ward		M.D. E.S.S. Hospital, Cambridge, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 15, 57.	
22c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		22d. LOCATION (City, town, or county) (State) Walston, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Holloway & Co.		ADDRESS Salisbury, Maryland.	
24a. REC'D BY REGISTRAR DATE 11/14/57		24b. REGISTRAR'S SIGNATURE John Rose Jr.	

BUREAU V. S.

NOV

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11852

Item 2 Filed 11-29-57 et

CERTIFICATE OF DEATH

11853

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Dorchester Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Secretary Md.</u>				c. LENGTH OF STAY IN 1b <u>Several Yr.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mattie Merrick's Con. Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ella</u> Middle <u>Mae</u> Last <u>Fitzhugh</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>10</u> Year <u>19 57</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1968</u>	9. AGE (In years last birthday) <u>89</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Howard Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Miles Earhart</u>				14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Alberts</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs. Dolle Baltimore Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>332x</u> IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 HOURS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12/31</u> , 19 <u>48</u> , to <u>10 NOV</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>10 NOV.</u> , 19 <u>57</u> , and that death occurred at <u>9:25 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>105 CHURCH ST.</u> DATE SIGNED <u>WALTER E. GUNBY JR</u> ACTUAL SIGNATURE <u>WALTER E. GUNBY JR</u> M.D. <u>CAMBRIDGE MD.</u> PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/13/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Joppa Church</u>		22d. LOCATION (City, town, or county) (State) <u>Madison Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>LeCompte Funeral Service Cambridge Md.</u>				24a. REC'D BY REGISTRAR <u>DATE 11/15/57</u>		24b. REGISTRAR'S SIGNATURE <u>John Trave Jr.</u>	

1000

1000

RECEIVED

NOV

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

: 11853 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11854

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE Md. b. COUNTY Dor.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge			c. LENGTH OF STAY IN 1b All life			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) E.S.S.H.				d. STREET ADDRESS Cambridge		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Frank Middle Fountain Last 				4. DATE OF DEATH Month Nov. Day 10 Year 1957			
5. SEX Male		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/28/86	
9. AGE (In years last birthday) 71 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber		10b. KIND OF BUSINESS OR INDUSTRY Plumbing		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME John Fountain			
14. MOTHER'S MAIDEN NAME Wilhemina Mills				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. 215-14-1465				17. INFORMANT Records E.S.S. Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (b) Arteriosclerosis (a), stating the underlying cause lost. DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH ? ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Mace Jr.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED 11/10/57							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/12/57		22c. NAME OF CEMETERY OR CREMATORY Dor-Mem-Park		22d. LOCATION (City, town, or county) (State) Cambridge, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE DeCompte Funeral Service				ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR DATE 11/13/57	
				24b. REGISTRAR'S SIGNATURE 			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. B.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11837

CERTIFICATE OF DEATH

11855

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester Co.</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) c. STATE <u>Md.</u> b. COUNTY <u>Dorchester Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cambridge Md. Hospital</u>				d. STREET ADDRESS <u>214 Sheppard Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>R.</u> Last <u>Gould</u>				4. DATE OF DEATH Month <u>November</u> Day <u>27</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/5/1883</u>		9. AGE (In years last birthday) yrs. <u>74</u>	10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Car Repairman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Auto</u>		11. BIRTHPLACE (State or foreign country) <u>Rhodesdale Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James M. Gould</u>				14. MOTHER'S MAIDEN NAME <u>Hester Cooper</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Mrs. Edith Gould</u> Address <u>Cambridge Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>162X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>bronchogenic carcinoma, Rt. Lung</u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs.</u> <u>3 -6 mo.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arterio sclerosis, generalized</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u>57</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug. 4th</u> , 19 <u>57</u> , to <u>Nov. 27</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Nov 27</u> , 19 <u>57</u> , and that death occurred at <u>4:15A</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>15 Locust street</u> DATE SIGNED <u> </u>							
ACTUAL SIGNATURE <u>Eldridge H. Wolff</u> M.D. <u>15 Locust street</u>							
PHYSICIAN'S NAME (Type) <u>Eldridge H. Wolff, M.D.</u> <u>Cambridge, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/29/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cambridge Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cambridge Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>LeCompte Funeral Service</u>				ADDRESS <u>Cambridge Md.</u>		24a. REC'D BY REGISTRAR DATE <u>11/29/57</u>	
						24b. REGISTRAR'S SIGNATURE <u>John M. ...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3

DEC 4 1950

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11856

11838

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester Co.</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Dorchester Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge Md.</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>303 Washington St.</u>				e. STREET ADDRESS <u>303 Washington St.</u>			
3. NAME OF DECEASED (Type or print) First <u>Nellie</u> Middle <u>Twilley</u> Last <u>Latta</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>28</u> Year <u>19 57</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/20/1879</u>	9. AGE (In years last birthday) <u>78</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Cambridge Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Wm. A. Twilley</u>				14. MOTHER'S MAIDEN NAME <u>Sophia E. Higgins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Miss Doris G. Cook Cambridge Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Insufficiency</u> DUE TO (c) <u>Coronary Heart Disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hours</u> <u>2 yrs</u> <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/28/57</u> , 19 <u>57</u> , to <u>11/28</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11/28</u> , 19 <u>57</u> , and that death occurred at <u>9:00</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Lawrence Maryanov</u> M.D.				ADDRESS (Street, city or town, state) <u>136 Race St. Cambridge, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Lawrence Maryanov</u>				DATE SIGNED <u>11/29/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/1/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cambridge Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cambridge Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>LeCompte Funeral Service</u>				ADDRESS <u>Cambridge Md.</u>		24a. REC'D BY REGISTRAR DATE <u>11/30/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>John M. ...</u>			

RECEIVED

DEC 4 1901

BUREAU V. S.

11839

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 5, See: Birth Cert. et.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>13 Cambridge, Md.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>9 Chesapeake Court</u>			d. STREET ADDRESS <u>19 Chesapeake Court</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Darlene</u> Middle <u>Midgett</u> Last <u>Midgett</u>			4. DATE OF DEATH Month <u>Nov.</u> Day <u>19</u> Year <u>1957</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May, 9, 1957</u>		9. AGE (in years last birthday) yrs. <u>8</u> Months <u>10</u> Days <u>10</u> Hours <u>10</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Harold Midgett</u>			14. MOTHER'S MAIDEN NAME <u>Avondorine Johnson</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congenital malformation of heart</u> <u>754.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause lost. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>6 Mo.</u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>John Mace Jr.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>Dr. John Mace Jr.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>11/20/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>1181</u>	22b. DATE THEREOF <u>11/21/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Waugh Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cambridge, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Herbert St. Clair</u>		ADDRESS <u>Cambridge, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>11/20/57</u>	24b. REGISTRAR'S SIGNATURE <u>John Mace Jr.</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registry prior to burial, cremation, or removal.

8 A 001128

AO1

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

11858/6

11854

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Cambridge				c. LENGTH OF STAY IN 1b 5 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital				d. STREET ADDRESS Easton Tilghman			
3. NAME OF DECEASED (Type or print) First Laura Middle BELLE Last Miller				4. DATE OF DEATH Month 11 Day 23 Year 1957			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-25-77	9. AGE (In years last birthday) 80 yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A				13. FATHER'S NAME Dawson Ball			
14. MOTHER'S MAIDEN NAME EVA HUNT				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. -				17. INFORMANT Eastern Shore State Hospital Records			
18. CAUSE OF DEATH [Enter only one cause prevailing for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension & Nephritis DUE TO (c) Gen Arterio-Sclerosis							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chr. Bronchitis							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 11-23 19 57 to 11-23 19 57 , that I last saw the deceased alive on 11-23 19 57 , and that death occurred at 4:55 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Easton Tilghman DATE SIGNED Edwin Friend M.D.							
ACTUAL SIGNATURE Edwin Friend M.D.							
PHYSICIAN'S NAME (Type) Edwin Friend							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-25-57		22c. NAME OF CEMETERY OR CREMATORY Tilghman M.E.		22d. LOCATION (City, town, or county) (State) Tilghman Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Moore				ADDRESS Tilghman, Maryland		24a. REC'D BY REGISTRAR JOV 24 1957	
24b. REGISTRAR'S SIGNATURE Mr. John Moore							

RECEIVED

NOV 22 1957

BUREAU V. S.

11840

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Dorchester Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		c. LENGTH OF STAY IN 1b 1 Day	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bishops Head Md. X			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Md. Hospital		d. STREET ADDRESS Bishops Head Md.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ida Middle Bloodsworth Last Moore		4. DATE OF DEATH Month Nov. Day 25 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/29/1879
9. AGE (In years last birthday) yrs. 78		IF UNDER 1 YEAR: Months Days Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Bloodsworth Is. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Andrew H. Bloodsworth		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Otis A. Moore		Address Harrington Del.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL FAILURE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSIVE CARDIOVASCULAR DISEASE DUE TO (c) 			INTERVAL BETWEEN ONSET AND DEATH 1 day.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) MALIGNANCY. Colon (Proven by X RAYS STUDIES)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 11 p. m. 25	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 11/24 , 19 57 , to 11/25 , 19 57 , that I last saw the deceased alive on 11/25 , 19 57 , and that death occurred at 12:55 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE W. H. Hanks		ADDRESS (Street, city or town, state) 104 Locust Cambridge, Md.	
PHYSICIAN'S NAME (Type) W. H. HANKS MD		DATE SIGNED 11/25/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/27/57	22c. NAME OF CEMETERY OR CREMATORY Dorchester Mem. Park	22d. LOCATION (City, town, or county) (State) Cambridge Md.
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		ADDRESS Cambridge Md.	
24a. REC'D BY REGISTRAR DATE 11/29/57		24b. REGISTRAR'S SIGNATURE John N. Jones Jr.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
DEC 4 1917
BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11855

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11860

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Taylors Island</u>		c. LENGTH OF STAY IN 1b <u>2 hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Taylors Island</u>				d. STREET ADDRESS <u>964 Renfrew St.</u>			
3. NAME OF DECEASED (Type or print) First <u>Delbert</u> Middle <u>A. Munshower</u> Last <u></u>				4. DATE OF DEATH Month <u>November</u> Day <u>8</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/17/26</u>	
9. AGE (In years last birthday) <u>31</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steel worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bethlehem Steel</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Walter Munshower</u>				14. MOTHER'S MAIDEN NAME <u>Ella Ridinger</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Wife</u> Address <u>964 Renfrew St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ac cidental Drow ning</u> <u>50.X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Skiff capsized.</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>10</u> a. m. <u>11-8-</u> 19 <u>57</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Chesapeake Bay</u>		20f. (City or town) (County) (State) <u>Taylors Island Dor.</u> <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>John Mace Jr.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>John Mace Jr.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>11/15/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Nat. Cemetery</u>	
				22d. LOCATION (City, town, or county) <u>Baltimore Md.</u>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Brooks Bradley</u>				ADDRESS <u>Baltimore Md.</u>		24a. REC'D BY REGISTRAR <u>John Mace Jr.</u>	
				24b. REGISTRAR'S SIGNATURE <u>John Mace Jr.</u>		DATE <u>11/13/57</u>	

RECEIVED

NOV 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution - Residence before admission) a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> Princess Anne	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital		d. STREET ADDRESS Route 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle William Last Parks, Jr.		4. DATE OF DEATH Month November Day 11 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-12-78
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months 79 Days 79 Hours 79 Min. 79	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John William Parks		14. MOTHER'S MAIDEN NAME Sarah Whitelock	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unkn.		16. SOCIAL SECURITY NO. -	
17. INFORMANT RECORDS - Eastern Shore State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial Pneumonia DUE TO Chronic Myocarditis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Hypertension (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome With Psychosis			
INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 5, 19 57 to November 11, 19 57 , that I last saw the deceased alive on November 11, 19 57 , and that death occurred at 4:06 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Edwin J. Ward		ADDRESS (Street, city or town, state) DATE SIGNED 11-12-57	
PHYSICIAN'S NAME (Type) Dr. Edwin J. Ward		M.D. E.S.S. Hospital, Cambridge, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/14/57	
22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		22d. LOCATION (City, town, or county) (State) Princess Anne Md	
23. FUNERAL DIRECTOR'S SIGNATURE James H. Henson		24. REGISTRAR'S SIGNATURE John M. Henson	
ADDRESS Princess Anne Md		DATE NOV 14 1957	

BUREAU V. S.

NOV 14 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11841

CERTIFICATE OF DEATH

11862

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cross Street				e. STREET ADDRESS Cross Street			
3. NAME OF DECEASED (Type or print) First Minnie Middle Veatrice Last Parrington				4. DATE OF DEATH Month Nov. Day 26 Year 1957			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 13, 1893	9. AGE (In years last birthday) 64 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Dorchester Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles W. Keene				14. MOTHER'S MAIDEN NAME Eliza Camper			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address Mrs. Flossie Stanley, Cambridge, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-sclerotic CVD. (c) P							INTERVAL BETWEEN ONSET AND DEATH 10 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 1 , 1957, to Nov 26 , 1957, that I last saw the deceased alive on Nov 25 , 1957, and that death occurred at 7 A M, from the causes and on the date stated above. ACTUAL SIGNATURE [Signature] M.D. Cambridge, Md DATE SIGNED Nov 30, 1957 PHYSICIAN'S NAME (Type) [Signature]							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/30/1957		22c. NAME OF CEMETERY OR CREMATORY Waugh Cemetery		22d. LOCATION (City, town, or county) (State) Cambridge, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE [Signature]				ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR DATE 12/3/57	
				24b. REGISTRAR'S SIGNATURE [Signature]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
DEC 4 1957
BUREAU V. B.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11842 CERTIFICATE OF DEATH

11863

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Dorchester Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cambridge Md. Hospital</u>		d. STREET ADDRESS <u>303 Choptank Ave.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>A.</u> Last <u>Phillips</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>27</u> Year <u>19 57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/8/1879</u>
9. AGE (In years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR: Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel Dunnock</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Margaret Hooper</u>		Address <u>Cambridge Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>Generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u></u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour <u></u> a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that I attended the deceased from <u>11/14/57</u> , 19 <u>57</u> , to <u>11/27</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11/29</u> , 19 <u>57</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. H. Hanks</u> M.D.		ADDRESS (Street, city or town, state) <u>104 Locust St Cambridge Md</u>	
DATE SIGNED <u>11/29/57</u>			
PHYSICIAN'S NAME (Type) <u>W. H. Hanks MD</u>		<u>CAMBRIDGE MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/30/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cambridge Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Cambridge Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>LeCompte Funeral Service</u>		ADDRESS <u>Cambridge Md.</u>	
24a. REC'D BY REGISTRAR <u>DATE 11/30/57</u>		24b. REGISTRAR'S SIGNATURE <u>John M. M.</u>	

RECEIVED

EO 4 1057

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11843

CERTIFICATE OF DEATH

11864

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Dorchester Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge Md.</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>124 Willis St.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Marcus H. Rhodes</u>				4. DATE OF DEATH Month Day Year <u>Nov. 2, 19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/19/1900</u>	9. AGE (In years last birthday) yrs. <u>56</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Janitor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Court House</u>		11. BIRTHPLACE (State or foreign country) <u>Brookview Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William R. Rhodes</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Callison</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <u>No</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT Address <u>Mrs. Marcus Rhodes 124 Willis St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL FAILURE</u> DUE TO <u>CORONARY ARTERY THROMBOSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>BRONCHIAL ASTHMA - UNRESOLVED PNEUMONIA</u> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19 11</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 20g. (City or town) (County) (State)							INTERVAL BETWEEN ONSET AND DEATH <u>22 days</u>
21. I certify that I attended the deceased from <u>11/19</u> , 19 <u>57</u> , to <u>11/2</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11/2</u> , 19 <u>57</u> , and that death occurred at <u>4A</u> M., from the causes and on the date stated above. ACTUAL SIGNATURE <u>W. H. Hanks</u> M.D. <u>104 Locust</u> ADDRESS (Street, city or town, state) <u>Cambridge Md.</u> DATE SIGNED <u>11/3/57</u> PHYSICIAN'S NAME (Type) <u>W. H. Hanks</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/4/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Dorchester Mem. Park</u>		22d. LOCATION (City, town, or county) (State) <u>Cambridge Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>LeCompte Funeral Service Cambridge Md.</u>				24a. REC'D BY REGISTRAR <u>11/4/57</u>		24b. REGISTRAR'S SIGNATURE <u>John Mace Jr</u>	

BUREAU V. S.

NOV 13 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11865

Reg. Dist. No.

11857

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rhodesdale - Rural				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Finchville				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rhodesdale - Rural			
f. STREET ADDRESS Finchville				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lula Middle R. Last Sheppard				4. DATE OF DEATH Month November Day 5 Year 1957			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 10, 1882	
9. AGE (in years last birthday) 75 yrs.		IF UNDER 1 YEAR Months 75 Days 0 Hours 0 Min. 0		IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Dorchester Co., Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Charles Evans				14. MOTHER'S MAIDEN NAME Jane Robinson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None		17. INFORMANT Address Elwood Sheppard, Rhodesdale, Md., R.F.D.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) Instant (c) Instant DUE TO (c) Instant							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Instant							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. 0 p. m. 0		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John Mace Jr.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Dr. John Mace Jr.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 11/7/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 9, 1957		22c. NAME OF CEMETERY OR CREMATORY Federal Hill Cemetery		22d. LOCATION (City, town, or county) (State) Federalburg, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalburg, Maryland				24a. REC'D BY REGISTRAR DATE 11/11/57		24b. REGISTRAR'S SIGNATURE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

NOV 13 1957

RECEIVED

FOR STATE
HEALTH DEPT.

11858

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Dorchester Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsburg Md.</u>		c. LENGTH OF STAY IN 1b <u>53 Yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsburg Md. x2</u> ✓			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Home-Williamsburg Md.</u>				d. STREET ADDRESS <u>Williamsburg Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>H.</u> Last <u>Smith</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>21</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/25/1870</u>		9. AGE (In years last birthday) <u>86</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Madison Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John E. Harrington</u>				14. MOTHER'S MAIDEN NAME <u>Annie E. Harrington</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Harrington Smith Williamsburg Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial failure</u> <u>9040</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture neck of Femur on Nov. 3, 1957</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Slipped and fell.</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>Nov. 3 57</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Williamsburg, Dor. Md.</u>		(County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John Mace Jr.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Dr. John Mace Jr.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>11/23/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/24/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Madison Church Cemetery</u>		22d. LOCATION (City, town, or county) <u>Madison Md.</u>		(State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>LeCompte Funeral Service Cambridge Md.</u>				24a. REC'D BY REGISTRAR DATE <u>11/23/57</u>		24b. REGISTRAR'S SIGNATURE <u>John Mace Jr.</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH
ALBANY, N.Y.

BUREAU V. 3

NOV 29 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11844 CERTIFICATE OF DEATH

11867

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester Co. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Dorchester Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.				c. LENGTH OF STAY IN 1b 2 Yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Home Cambridge Md.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 Cambridge Md.			
				d. STREET ADDRESS 1 Cambridge Md.			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Julia Middle M. Last Spedden				4. DATE OF DEATH Month Nov. Day 15, Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/11/1976	
				9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR: Months Days Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Castle Haven Dorchester Col	
13. FATHER'S NAME William M. Mitchell				14. MOTHER'S MAIDEN NAME Mary Emily Spedden			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None		17. INFORMANT Sidney Spedden Cambridge Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 490X PNEUMONIA (LOBAR) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 				INTERVAL BETWEEN ONSET AND DEATH 12 HRS.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE, CONDITION GIVEN IN PART I (a) GENERAL ARTERIOSCLEROSIS - OLD RIGHT HEMIPLEGIA				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 6/27, 1957 to 11/15, 1957 , that I last saw the deceased alive on 11/15, 1957 , and that death occurred at 12:20 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Walter E. Gunby Jr. M.D.				ADDRESS (Street, city or town, state) 105 CHURCH ST. Cambridge Md.			
DATE SIGNED 18 Nov. 57							
PHYSICIAN'S NAME (Type) WALTER E. GUNBY JR. CAMBRIDGE MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/17/57		22c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery		22d. LOCATION (City, town, or county) (State) Cambridge Md.	
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service				ADDRESS Cambridge Md.		24a. REC'D BY REGISTRAR DATE 11/20/57	
				24b. REGISTRAR'S SIGNATURE John M. ...			

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Signature of informant		12. Signature of witness	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery	
16. Signature of health officer		17. Signature of coroner		18. Signature of jury	
19. Signature of jury		20. Signature of jury		21. Signature of jury	
22. Signature of jury		23. Signature of jury		24. Signature of jury	
25. Signature of jury		26. Signature of jury		27. Signature of jury	
28. Signature of jury		29. Signature of jury		30. Signature of jury	
31. Signature of jury		32. Signature of jury		33. Signature of jury	
34. Signature of jury		35. Signature of jury		36. Signature of jury	
37. Signature of jury		38. Signature of jury		39. Signature of jury	
40. Signature of jury		41. Signature of jury		42. Signature of jury	
43. Signature of jury		44. Signature of jury		45. Signature of jury	
46. Signature of jury		47. Signature of jury		48. Signature of jury	
49. Signature of jury		50. Signature of jury		51. Signature of jury	
52. Signature of jury		53. Signature of jury		54. Signature of jury	
55. Signature of jury		56. Signature of jury		57. Signature of jury	
58. Signature of jury		59. Signature of jury		60. Signature of jury	
61. Signature of jury		62. Signature of jury		63. Signature of jury	
64. Signature of jury		65. Signature of jury		66. Signature of jury	
67. Signature of jury		68. Signature of jury		69. Signature of jury	
70. Signature of jury		71. Signature of jury		72. Signature of jury	
73. Signature of jury		74. Signature of jury		75. Signature of jury	
76. Signature of jury		77. Signature of jury		78. Signature of jury	
79. Signature of jury		80. Signature of jury		81. Signature of jury	
82. Signature of jury		83. Signature of jury		84. Signature of jury	
85. Signature of jury		86. Signature of jury		87. Signature of jury	
88. Signature of jury		89. Signature of jury		90. Signature of jury	
91. Signature of jury		92. Signature of jury		93. Signature of jury	
94. Signature of jury		95. Signature of jury		96. Signature of jury	
97. Signature of jury		98. Signature of jury		99. Signature of jury	
100. Signature of jury		101. Signature of jury		102. Signature of jury	

BUREAU V. S.

NOV 25 1957

RECEIVED